Federal Update for May 26 - 30, 2014

Sanders to introduce VA accountability bill

The chairman of the Senate Veterans' Affairs Committee is planning to introduce a bill to ensure military veterans receive better medical treatment amid allegations of treatment delays at VA hospitals.

Sen. Bernie Sanders (I-Vt.) said his proposal would increase accountability and improve veterans' health care benefits, education and job-training programs. He plans to introduce the legislation after Congress returns from its Memorial Day recess on June 2.

"In recent years, as a result of the wars in Iraq and Afghanistan, 1.5 million more veterans have entered the VA health care system," Sanders said in a statement Friday. "Congress must do everything possible to make certain that the VA has the financial resources and administrative accountability to provide the high-quality health care and timely access to care that our veterans earned and deserve." The Vermont senator said his legislation would also restore a one-percent cut in annual cost-of-living payments for military pensions.

Republicans have accused the Obama administration of attempting to cover up issues at the VA that have resulted in some veterans being delayed treatment. Sanders has introduced the VA improvement bill before, but said Senate Republicans complained about the cost. Sanders' office said the measure would cost $21 billion over the next 10 years.

Sanders said the importance of providing proper care to veterans should outweigh concerns about the costs of the legislation. "If you think it's too expensive to take care of our veterans then don't send them to war," he said this week in an exchange with Sen. Marco Rubio (R-Fla.).

Rubio said Saturday in an op-ed in the *Tampa Bay Times* that the VA's problems could not be solved with just more money.

Rubio touted his own bill to address the VA controversy that he said would make it easier for officials at the agencies to be fired for mistakes involving veterans' care.

"Over this Memorial Day holiday, I encourage people to let their senators know why action must be taken to hold people accountable for the mistreatment of our veterans," Rubio wrote. "Current law obstructs this accountability by forbidding the firing of negligent and incompetent VA officials, which is why my legislation is so important."

John Kline Statement on Sec. Shinseki

"As a 25-year veteran of the U.S. Marine Corps, one of the reasons I came to Congress was to ensure promises made to our veterans are promises kept. We must keep faith with America's heroes, which is why I am outraged by recent reports highlighting the severe mismanagement and lack of accountability across the VA. Swift and stern action must be taken to address this deplorable misconduct. General Shinseki is a decorated Vietnam veteran and I appreciate his service to our country, but the entire leadership of the VA must be held accountable which is why I'm calling on him to resign – and if he doesn't, the President should relieve him of his duties – so we can move forward, address the systemic failures, and restore faith to the American people that our veterans will receive the care they deserve."

Note: Last week, the House of Representatives passed the "Department of Veterans Affairs Management Accountability Act" (H.R. 4031), bipartisan legislation that would give the Secretary of the Dept. of Veterans Affairs (VA) the authority to hold accountable and terminate senior leaders working at the VA who could have played a role in the alleged misconduct. Under current law, removal of senior government officials is a bureaucratic process. H.R. 4031 allows the Secretary of the Dept. of Veterans Affairs to circumvent this existing process and remove Senior Executive Service (SES) managers whose performance warrants removal.

John Kline serves on the House Armed Services Committee. He also is the Chairman of the House Education and the Workforce Committee. He and his wife, Vicky, live in Burnsville.

IG: 1,700 Phoenix-area vets omitted from wait lists

By Patricia Kime and Leo Shane III, Staff writers
MilitaryTimes

More than 1,700 veterans were left off the official wait list for a primary care appointment at the Veterans Affairs Phoenix medical center, a purposeful omission that allowed hospital administrators to receive performance bonuses, the VA's inspector general has found.

In an interim report into allegations of secret wait lists and subsequent patient deaths at the Phoenix VA facility, the department's top investigator found "serious conditions at the Phoenix Health Care System," including 1,400 veterans who did not have appointments but were on the facility's electronic waiting list, as well as the 1,700 who have yet to be entered into the system.

"Since multiple lists we found were something other than the official electronic wait list, these additional lists may be the basis for allegations of creating 'secret' wait lists," acting VA Inspector General Robert Griffin wrote.

Griffin's report did not include information on his office's investigation into whether the scheduling issues delayed diagnosis or care, or led to deaths.
He said the review needed to include a variety of records, such as VA and non-VA medical records, death certificates and autopsy results and his office has issued subpoenas where needed for the information.

For the initial investigation, the VA IG office reviewed a statistical sample of 226 appointments at Phoenix and found that the veterans waited an average of 115 days for their first primary care appointment, with 84 percent waiting more than 14 days. VA national data showed these veterans waited on average 24 days for their first primary care appointment and only 43 percent waited more than 14 days.

“We recommend the VA secretary initiate a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition,” Griffin wrote. He added that the IG will hand over the 1,700 names so VA can expedite their appointments.

“These veterans were and continue to be at risk of being forgotten or lost in Phoenix’s convoluted scheduling process,” Griffin said.

The preliminary findings are the first admission from federal officials that thousands of veterans were left waiting for medical care even as hospital administrators reported no problems finding appointments for their patients. The report is likely to renew calls for swift action against Phoenix officials for covering up care delay problems, as well as accountability for officials higher up in VA. In the report, investigators said they do not believe the problem is in only Arizona. “We are finding that inappropriate scheduling practices are a systemic problem nationwide,” they wrote.

Following release of the interim report, VA Secretary Eric Shinseki issued a statement describing the findings as “reprehensible” and said the department will “aggressively and fully implement the remaining OIG recommendations.”

“I am directing that the Phoenix VA Health Care System immediately triage each of the 1,700 Veterans identified by the OIG to bring them timely care,” Shinseki said. He added that he does not plan to take further personnel actions against hospital administrators — three of whom were placed on administrative leave in April after news of the allegations broke — at the VA IG’s request.

The findings prompted several lawmakers to weigh in Wednesday afternoon, including Rep. Jeff Miller, R-Fla., who called for VA Secretary Eric Shinseki‘s resignation and urged the Obama Administration to launch a criminal probe. Miller previously had said he would wait for the IG’s findings before calling for senior leadership to step down.

“Shinseki is a good man who has served his country honorably, but he has failed to get VA’s health care system in order despite repeated and frequent warnings from Congress, the Government Accountability Office and the IG,” Miller said. “It’s time for him to go.”

Miller said Attorney General Eric Holder should untertake a criminal investigation into the issues. His call for Justice Department involvement follows similar requests from Sen. Richard Blumenthal, D-Conn., and Rep. Adam Kinzinger, R-Ill.

Walz Statement on Interim VA IG Report

Washington, DC [5/28/14] – Today, Representative Tim Walz (MN-01), Member of the U.S. House Veterans' Affairs Committee and the highest ranking enlisted soldier to ever serve in Congress, released the following statement after the VA Inspector General released an interim report substantiating serious concerns at the Phoenix VA medical facility.

"My number one goal as both a veteran and a Member of the VA Committee is to ensure our veterans get the support and care they have earned and deserve. The findings in the VA Inspector General's interim report are inexcusable and unacceptable. The IG's report makes it clear that some veterans have been let down in unfathomable ways and those responsible must be held accountable.

"Secretary Shinseki is one of the most honorable and loyal men I have ever met. He's dedicated his entire life to the betterment of our nation and caring for our brave men and women in uniform. It's a shame that he and other veterans were let down by certain people working under him at the VA, but ultimately the buck stops with the Secretary. That is why today, I believe it would be best if Secretary Shinseki stepped down. We need to fix the systemic problems outlined in the IG report and restore veterans' faith in the system."